ALASKA SHOULDER
ORTHOPAEDIC INSTITUTE

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Release of Medical Information

I, _____ (Patient), Authorize _____

(Address/Fax)_____ (Phone)

To disclose my protected health information to (Name) _____

(Address/fax) _____(Phone)_____

- o Treatment
- o Coordination of Care
- o Payment of Services
- o Other: _____

The information that may be released is as follows:

- o History & Physical
- o Lab Reports
- o Treatment Record
- o Medication Record
- o Hospital Reports
- o Progress Notes
- o Radiology Reports / Images
- o Pathology Reports
- o Operative Reports
- o All Records in relation to:

  _____

  (Diagnosis, symptoms, illness, injury)
- o Other: _____

This Release of Information will expire on _____ or one year after date of signature, whichever is first.

I understand that I may revoke this Authorization at any time by submitting a written request to Practice Manager at Alaska Shoulder and Orthopaedic Institute.

I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment.

Patient Signature: _____ **Date:** _____

Guardian Signature: _____